New Jersey Office of the Child Advocate Newsletter

Volume 2, Issue 3
Fall 2005

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Child Advocate to Release Health Report on Children in Foster Care

State Child Advocate Kevin M. Ryan will release findings and make recommendations in December based on a review of health records of children in out-of-home placement. The review, which was led by Keri Logosso, Esq., director of health advocacy, and Anne Armstrong-Coben, M.D., of the OCA Board of Advisors, probed the efficacy of the State's emerging health care safety net for children. Those interested in receiving an electronic version of the report should email info@childadvocate.state.nj.us.

Keri Logosso, Esq., director of health advocacy, visits with children at a Mercer County pediatric program.

Ryan and Department of Human Services (DHS) Deputy Commissioner Kathi Way recently agreed to jointly convene a working group of medical experts, including Department of Health and Senior Services Commissioner Fred Jacobs, M.D. and the heads of New Jersey Regional Diagnostic and Treatment Centers, to identify the strengths and weaknesses of the State's current approach to the medical needs of children in foster care.

The group is expected to make recommendations for improving the delivery of coordinated health care services to at-risk children.

Many Illegally Held Children Released

The Office of the Child Advocate confirmed that all but two youth who had been held in detention illegally, waiting for a therapeutic child welfare or mental health placement, were released from the 17 detention centers to alternative treatment placements on September 30, 2005.

A follow-up review of the number of children in detention centers on October 15, 2005, revealed four children awaiting a child welfare or mental health placement following disposition.

Youth who have mental and behavioral health needs are particularly ill-suited to detention for long periods of time.

A second count of illegally held youth on October 30, 2005 indicated at least six children were being held post-disposition, yielding an upward trend that must be closely monitored and reversed.

Continued on page 3

From the Child Advocate

One of the primary concerns identified by the Office of the Child Advocate's (OCA) November 2004 juvenile justice report was overcrowding in some of the state's 17 county detention centers.

One year later, the outlook is considerably brighter. In his recently released "2004 Juvenile Detention Statistics Report," Juvenile Justice Commission (JJC) Executive Director Howard Beyer reports detention populations throughout the state are at their lowest levels in 10 years.

Detention centers across the state averaged 806.3 youth on an average daily basis, compared with 932.6 in 2003 and 1004.8 in 2000.

These developments are the result of significant improvements made in both of the areas that affect detention populations: the number of youth admitted to detention and their lengths of stay.

Admissions to detention centers were lower in 2004 (11598) than 1993 (12108) and have dropped 16 percent since 2000.

The average length of detention is at its lowest point since 1997 (25.4 days), a four percent reduction from 2000.

In Essex and Camden counties - two of the first counties to embrace the systemic reform initiative known as the Juvenile Detention Alternatives Initiative (JDAI) - detention rates for children have spiraled downward.

Combined, Essex and Camden saw a reduction of 87.7 youth in the detention centers on an average daily basis, nearly three-quarters of the state's 126.6 youth reduction in average daily population between 2003 and 2004.

For example, in 2003, the census of the Camden Detention Center averaged 94.6 youth and reached a high of 131, despite a licensed capacity to house only 37 youth. Overcrowding made the building unsafe for children and staff alike.

The JDAI provided a forum for the OCA, the JJC and Camden County leadership to agree to limit the number of youth admitted to the center, and for all involved stakeholders to work aggressively to reduce the number of children detained, all of which resulted in the average daily census dropping precipitously.

The judiciary in Camden played a pivotal role in identifying safe and appropriate alternatives to detention for children who posed no threat to public safety.

Camden County has also begun construction on a new state-of-the-art building that should ameliorate overcrowding concerns when it is completed next year.

As a result of those efforts, in 2004 the average daily census was 79.4 kids, a 16.4 percent reduction, and early estimates indicate that 2005 will see an even greater reduction.

We can build a better New Jersey for all our children, regardless of their families' income or the color of their skin.

While detention populations continue to decline, overcrowding is a widespread problem around the State. In 2004, seven of the 17 county detention centers held more youth on an average daily basis than their rated capacity, representing no change from 2003. This highlights the need to ensure that we use detention appropriately, and that we make certain our detained youth are safe.

In order to accomplish both of these objectives, community advocates and lawmakers have begun to consider amendments to the statutory criteria for admission to detention.

The amendments could remove low-level offenders and youth with no history of failing to appear in court from detention. The amendments could bring many of the improvements we have seen in JDAI counties to the rest of the State and strengthen the efforts of local planners to emphasize appropriate and safe alternatives to detention.

Meanwhile, juvenile violent crime in New Jersey has fallen by 34 percent over the last ten years and by ten percent since 2000. Juvenile arrests tracked by the FBI have dropped 47.4 percent over the ten-year period since 1995 and 17.5 percent since 2000.

While New Jersey has made substantial progress in lowering youth crime and the number of youth in detention, we have not yet improved the continuing problem of minority overrepresentation in detention centers.

While minority youth make up only 34 percent of New Jersey's general youth population, in 2004 they made up 88.2 percent of youth in detention. This represents a slight worsening of the problem since 2002, when 81.5 percent of youth in detention were children of color. Lowering the overrepresentation of minority youth in detention remains an area where we have yet to see significant progress. We can do better.

We can build a better New Jersey for all our children, regardless of their families' income or the color of their skin. If we want to keep our streets safe, our prisons empty and our youth engaged in their communities, we now have a wonderful opportunity to do so.

Kevin M. Ryan

Many Illegally Held Children Released, *continued*

Continued from page 1

The OCA publicly identified the illegal detention of hundreds of New Jersey youth as a problem of long-standing in a November 2004 report on the treatment of children with serious mental health needs in juvenile detention centers.

The OCA, aided in large part by the staff of the 17 county detention centers, monitored the number of youth waiting in detention for therapeutic placements, and how long these youth remained in detention. That monitoring revealed deliberate but traceable progress from May to September 2005.

As recently as August 30, 2005, 30 youth waited in detention centers for court-ordered treatment. However, a steep decline during the month of September paved the way for the announcement that nearly all of the youth had been removed by September 30th.

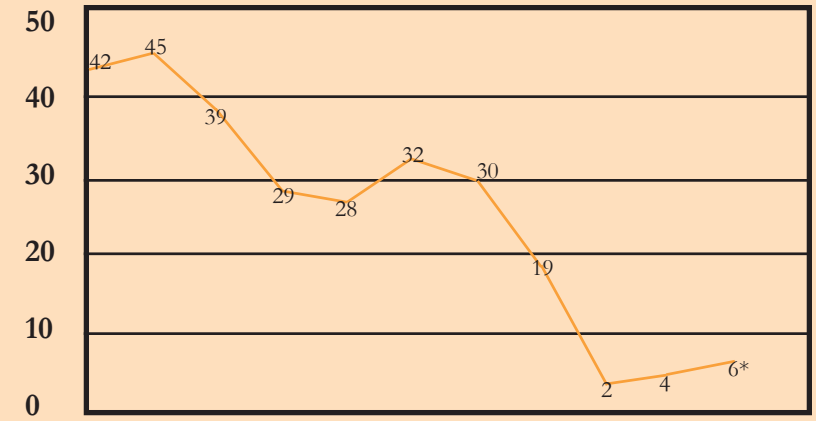
For the past year, the OCA has advocated for the safe removal of these youth from detention centers to more appropriate settings. Youth who have mental and behavioral health needs are particularly ill-suited to detention for long periods of time.

"The stakes for these kids are terribly high," said Brian Hancock, senior assistant child advocate and coordinator of the OCA's juvenile justice advocacy.

This was well-documented by the OCA's November 2004 report, which found more than 90 suicide attempts or threats in just three of the 17 county detention centers during an eight-month period in 2003.

The report objected to holding youth in the most secure, least therapeutic environments after courts ordered them placed in non-secure treatment programs.

Youth Held Illegally in Detention Post-Disposition Awaiting Mental Health Treatment or Child Welfare Placement



Date	5/15	5/30	6/15	6/30	7/30	8/15	8/30	9/15	9/30	10/15	10/30
No. of Youth	42	45	39	29	28	32	30	19	2	4	6*

Source: New Jersey Detention Centers

* Data review still underway at time of publication.

"We hope that the improvements made by the State to remove these youth from detention will be sustained."

-First Assistant Child Advocate Jennifer Velez

The result of their incarceration is often a painful deterioration of their mental health status, and attendant safety risks to the residents and staff of the detention centers.

"Today, no children wait more than a few days past their court disposition," said Department of Human Services (DHS) Commissioner Jim Davy in announcing DHS' new policy on October 6, 2005.

DHS' legal obligation to remove a child from detention is triggered by a court's decision to order the youth disposed to a child welfare or mental health placement.

In light of DHS' commitment to place disposed youth promptly, the key to limiting the length of time children languish in detention now rests with family court judges throughout New Jersey whose early dispositions of detained children should result in their near-immediate placement by DHS. The OCA will continue to monitor and report on DHS' progress.

"We hope that the improvements made by the State to remove these youth from detention will be sustained," said First Assistant Child Advocate Jennifer Velez. "Monitoring the progress of DHS in transforming the recent improvement into long-term reforms will be a focus of our juvenile justice work going forward."

Among the announced efforts to sustain the reforms is the piloting of an information-sharing system between the courts and DHS, which could allow both entities to track adjudicated and disposed youth awaiting placement in detention.

The DHS Office of Children's Services also announced a restructuring of its staff to better monitor progress in placing detained youth, and the expansion of residential treatment and treatment home capacity throughout the State (*see chart on page 5*).

Each of these is an important step toward creating a system that could efficiently and effectively deliver services to one of New Jersey's most vulnerable populations.

For more information on the OCA's juvenile justice work, go to childadvocate.nj.gov.

POLICY BRIEF: Brisbane Alternatives

Monitoring of the Children's Mental Health System

As the Department of Human Services (DHS) prepares to close the Arthur Brisbane Child Treatment Center in December, the Office of the Child Advocate is reviewing capacity-building within the State's behavioral health system for children to promote the safety, treatment and recovery of our youth.

The Child Welfare Reform Plan contains a very promising series of commitments to the deinstitutionalization of New Jersey's children and the development of adequate community capacity to care for children with mental and behavioral health needs. The State's plan to develop a comprehensive, integrated system of care for youth with serious emotional and behavioral disorders has been implemented and expanded over the past five years. Now, nearly complete, the system represents annual investments in excess of $330 million.

The deployment of many new resources in a statewide system represents an enormous opportunity to address the unmet mental health needs of youth. But two recent reports from influential panels raise questions about the efficacy of the current system, which must be addressed.

According to Acting Governor Richard J. Codey's Task Force on Mental Health, **"**individuals, agencies and even persons working for the child behavioral health system, perceive the child behavioral health system as inaccessible, irrational and duplicative. While many hard-working and well- intentioned people at both the state and community levels are doing their best to make the current system work, testimony to this committee and extensive provider feedback reveals deep frustration instead of the integrated synergistic relationship needed for the system to work."

For its part, the New Jersey Child Welfare Panel, which monitors compliance with the Child Welfare Reform Plan, raised questions in its October 2005 report about whether the system had been constructed in a fashion to achieve positive outcomes for children. The Panel noted that a recent assessment indicated that "as many as 25 percent of New Jersey children in residential treatment settings and group homes no longer need to be in these expensive and restrictive settings. They are ready for return to their own families or, if this is not possible because of safety issues, transfer to a foster family."

The Panel continued, "Facilitating such movement and ensuring that there are sound plans in place for community-based services are critical tasks that have been assigned to Youth Case Managers. If these tasks are accomplished routinely, New Jersey will improve the lives of two groups of children – those who are ready to return to the community, and those who are in inappropriate settings (detention facilities, shelters, and out-of-state placements) because there is no room for them in residential treatment programs."

Yet, the Panel concluded that "there is little to indicate that the movement of children from congregate care programs to families is happening routinely or effectively. The Youth Case Management programs face significant challenges, including high caseloads; lack of clarity about the division of responsibility

Continued on page 6

Based on a needs assessment developed by Dr. John Lyons for DHS in April 2005, DHS reports the need for 311 beds for out-of-home placement for Fiscal Year 2006. The current DHS plan to meet this need is as follows:

- **Specialty Residential Treatment –** DHS will add 96 beds for youth who might otherwise go out of state because of their complex needs and behaviors. These programs are designed to meet the needs of special populations, including children who have exhibited behaviors in the area of fire setting and aggression. These beds do not represent a net gain to the system's residential treatment capacity, as they will essentially replace 110 beds lost over a year ago with the closure of the Lipman Hall RTC program.

- **Intensive Residential Treatment Centers (IRTC) -** According to DHS' recent Request for Proposals, IRTCs are envisioned as highly structured, non-hospital based, out-of-home treatment settings that bring comprehensive and specialized diagnostic and treatment services to youth and their families. This is a new service, the clinical contours of which continued to evolve at the time of publication. Since they will be the locus of treatment for children who in many instances have been unsuccessful in prior attempts at treatment, IRTCs will be closely monitored and evaluated for lengths of stay and resident outcomes. Whether IRTCs will be effective in meeting the specialized diagnostic and treatment needs of New Jersey's youth is difficult to predict since, presently, we are without final policy or regulations to guide these facilities.

- **Treatment Home Expansion –** DHS will establish an additional 215 treatment home beds and 40 emergency treatment home beds. Providing therapeutic care in a normal setting of family and community is a critical component of the system. DHS should be lauded for this endeavor. The development of these beds will require recruitment, training and ongoing support for a large number of homes, which will likely be a significant challenge.

POLICY BRIEF: Brisbane Alternatives

New Behavioral Health Services for Children as of October 2005

CCIS Intermediate Hospital - New Capacity	No. of Beds in Contract	No. Currently Operational	Comments
South Jersey Health Center at Bridgeton	12	0	Feb. 1 unit operational. Jan-Feb will utilize existing space to serve some children.
Bergen Regional Medical Center	8	8	
Total New Intermediate	**20**	**8**	
IRTC			**All beds are reportedly no-eject/no-reject.**
Trinitas Hospital	4	4	This is a specialized program for detained youth.
YCS Hackensack	7	7	Mueller Hall is a specialized program for youth, ages 11 to 13.
YCS Kilbarchan, Paterson	8	0	The program is scheduled to open January 1, 2006, and is designed to serve youth 14 to 18 years old.
CFG Camden	7	0	This program, based at Virtua, is designed to serve youth, ages 11 to 13, and is scheduled to open January 1, 2006.
CFG Camden	8	0	This program, based at Virtua, is designed to serve youth, ages 14 to 18, and is scheduled to open January 1, 2006.
Carrier, Belle Meade	10	0	This program is designed to serve youth, ages 14 to 18, and is scheduled to open January 1, 2006.
Total New IRTC	**44**	**11**	
Specialty RTC		**No. Currently Operational**	**All beds are reportedly no-eject/no-reject.**
Trinitas, Elizabeth	15	0	The program is expected to open in January or February 2006.
Keystone	40	40	All of these beds are out-of-state. It is expected by DHS that the beds will become available in NJ through this provider within one year.
Bonnie Brae, Somerset County	17	17	This includes 5 new Step-Down/ Transitional beds; 12 new program slots became available October 28, 2005 for youth, ages 13 and 14.
Capital Academy, Camden	24	0	Opening of this program is pending the completion of major renovations of an assisted living facility. The 24 new beds are in addition to 22 existing beds which will be relocated from a Mercer County location to the newly-renovated space in Camden County.
Childrens Home, Mt. Holly	5	5	The Anderson Program is a step-down for youth with complex aggressive behaviors.
YCS Voorhees	10	10	
YCS Kilbarchan, Paterson	6	6	
Total New Specialty RTC	**117**	**78 (38 in NJ)**	**Of the 78 operational beds, 38 are available in NJ as of October 31, 2005.**
New RTC			
Center for Family Services, Camden	8	8	
Vision Quest, AZ	5	5	All 5 slots are part of the "Wagon Train" program in AZ.
Vision Quest, New Lisbon	20	15	These 20 beds represent an expansion of an existing 105 bed program. The next 5 beds are expected to be ready in December 2005.
Vision Quest, New Lisbon	5	5	All 5 slots are emergency beds and have been available since November 2004.
Keystone Pennsylvania	1	1	The bed is out of State.
Keystone Virginia	3	3	The beds are out of State.
Children's Home, Mt. Holly	4	0	These beds represent a girls stabilization unit post-detention, and are reportedly no-eject/no-reject.
Family Service of Burlington	8	0	All beds are to be reserved for youth post-detention, and are reportedly no-eject/no-reject.
CFG Camden	8	8	These beds are located at Virtua Hospital. The provider describes this as a specialty residential program.
Total New RTC	**62**	**49 (40 in NJ)**	**Of the 49 operational beds, 40 are available in NJ as of October 31, 2005.**
Total Out-of-Home Treatment Capacity	**244**	**146 (97 in NJ)**	**As of October 2005, 60 percent of DCBHS total predicted capacity is presently available, of which 66 percent is available in NJ.**
Treatment Home Beds	**252**	**13**	
No. Children Sent Out-of-State for Treatment	**Jan 05 196**	**Sept 05 245**	**+ 49 children 25 percent growth**

POLICY BRIEF: Brisbane Alternatives

Continued from page 4

between YCM workers and DYFS workers; the need for continued training and skill development; and in some instances lack of sufficient funding for community services."

Data suggests a new trend toward out-of-state mental health care for New Jersey youth. The number of children being served out of state has increased from 196 in January 2005 to 245 in September 2005, a 25 percent increase. Similarly, of the new residential treatment beds authorized by DHS in the last year, 142 are currently operational, only 71 of them in the State of New Jersey. As of October 2005, 58 percent of the Division of Child Behavioral Health Services' (DCBHS) overall projected capacity was presently available and operational, half of which is in New Jersey.

To the extent that the expansion of out-of-state therapeutic care has assisted DHS to decrease the likelihood children will languish illegally in detention centers awaiting mental health treatment, the growth of non-New Jersey placements clearly has an immediate upside.

And not all out-of-state care is far from New Jersey children's homes. Indeed, some placements are nearer for families than alternate in-state programs. But much out-of-state care is distant and we would do well not to impose upon children the choice whether they languish in jails in New Jersey or receive care away from their families out-of-state.

The New Jersey Child Welfare Reform Plan insists on systems reform that will allow children to be served as close to home as possible, so this trend should begin moving in the opposite direction.

As Brisbane prepares to close, DHS has expanded capacity through newly created Intensive Residential Treatment Centers and hospital-based CCIS Units, which provide two levels of inpatient psychiatric services to children in New Jersey.

Short-term CCIS units are acute-care, psychiatric, inpatient units for youth ages 5-18, who are actively in a state of mental health crisis (i.e. suicidal, actively psychotic, etc.). Intermediate Psychiatric Hospital Units provide up to 90 days of intensive treatment.

DHS has contracted with two new Intermediate CCIS units to provide care and treatment for children: (1) Bergen Regional Medical Center, a county-operated facility that is also the largest hospital facility in the State (with acute care, long term care and behavioral health services), and (2) South Jersey Health Center at Bridgeton, a facility also offering emergency and outpatient services, formerly known as Bridgeton Hospital.

The OCA is tracking the commitments made for expansion of services to replace Brisbane, with a particular focus on what is operational and ready to serve children and their families safely.

The chart, on page 5, outlines our findings to date in this monitoring. As of October 2005, there are 243 new residential treatment beds for children contracted by DCBHS. This roll-out has resulted from an enormous amount of administrative work by DHS staff and deserves acknowledgment and praise.

Our review indicates that presently 142 of the 243 beds are currently operational, and 71 of them are operating in the State of New Jersey.

The Office of the Child Advocate will advocate for a system that:

- **Does not warehouse kids** – Children should not languish in hospital or residential settings because less restrictive care is unavailable.

- **Is ready to provide care and services** – Timing of the planned closure of Brisbane and the start-up of new IRTC programs leaves no margin for error. New programs must be ready with appropriate training, procedures, staffing and services to meet the needs of kids.

- **Is safe and accountable –** Many of the program models are new and require specific licensing and operational standards. DHS must closely monitor these new programs to strengthen providers' ability to meet the needs of youth, prevent abuse and ensure that levels of care and quality of services meet the contracted goals, on an ongoing basis. Accountability is vital.

- **Does not lead to the continued growth of out-of-state placements for New Jersey's children** – Since January, the number of children placed by DHS in out-of-state residential treatment has grown. If our system is working appropriately, we will reverse this trend in the next 12 months and move to the virtual elimination of out-of-state placements.

- **Is moving in the direction of training and funding for providers to deliver proven interventions** - Although more services exist in the community, there is no data yet to demonstrate whether these investments are achieving positive outcomes for children, and there is not yet a sufficient emphasis on evidence-based, community-based, therapeutic interventions.

The OCA will continue to monitor the start-up of new programs to replace Brisbane. Pursuant to our statute, we will conduct on-site evaluations of programs and support efforts to build a safe continuum of care for kids with serious emotional disorders.

Child Advocate's Helpline Serving Youth at Risk

877-543-7864

Mother Of Boy With Developmental Disabilities Was Desperate For Help

Joseph* is an autistic 12-year-old boy with a closed Division of Youth and Family Services (DYFS) case and a history of behavioral issues that has resulted in injury to himself and others.

Joseph's mother contacted our Helpline staff to find assistance in managing Joseph's behavior, which often included running away from home and on multiple occasions trying to jump into an unattended pool, despite Joseph's inability to swim.

Joseph's mother, a single parent working full-time, reported that she was experiencing difficulty accessing services from Special Child Health Services, the Division of Developmental Disabilities (DDD) and other service providers.

Our Helpline staff recommended that Joseph's mother call her concerns into the DYFS centralized screening hotline after Joseph ran away multiple times, and Helpline staff assisted her with reporting the problems.

DYFS then undertook a child welfare assessment for Joseph, and placed him in a camp program for one week, while our Helpline staff worked with DDD to identify available services for Joseph.

Due to the advocacy of our Helpline staff, DDD has provided Joseph's mother with financial support for a new babysitter and has prioritized Joseph for a placement at a residential treatment center. Since calling the Helpline and accessing family support services, Joseph's mother has reported that his behavior has become more manageable, and she is better able to cope with his special needs.

FOR MORE INFORMATION ON THE CHILD ADVOCATE HELPLINE, VISIT OUR WEB SITE:
childadvocate.nj.gov

Suicidal Teen Freed From Detention

Youth Now Residing in a Residential Treatment Center

Thomas* is a teenager with a history of mental illness, who had been sentenced to 18 months probation for assaultive behavior towards his mother and siblings, essentially engaging in behavior symptomatic of his mental health problems.

When Thomas went to court, a Youth Case Management (YCM) agency was ordered to find him an appropriate placement, but he was returned to the county detention center to wait for an opening in a residential treatment center.

Thomas' mother called our Helpline for assistance in ensuring that Thomas was placed in a facility where he could access the continuous mental health care that he needed pending residential placement.

Thomas tried to commit suicide three times within a month of being at the detention center and was hospitalized at a child and adolescent psychiatric inpatient unit in order to stabilize his behavior.

Thomas' mother told the Helpline staff that she was advised it could be a year before the YCM agency would find him a placement and that he might have to return to detention pending placement.

The Helpline staff recommended that the YCM agency pursue placement on a child and adolescent psychiatric intermediate care unit that could continue to provide treatment on an interim basis pending placement.

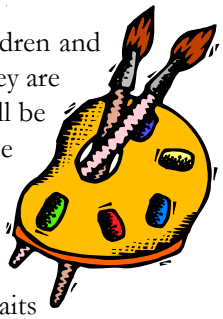
YCM informed the judge of this alternative placement option and he agreed to transfer the youth to the intermediate care unit.

Thomas was able to stay at the intermediate care unit recommended by the Helpline staff until he was subsequently placed in a New Jersey facility that serves emotionally disturbed youth, where he is now receiving structured mental health care. Thomas' mother reports to the Helpline staff that he is doing well in his new setting and is glad to be out of detention.

**Names have been changed.*

Attention Principals, Art Teachers and Parents:

"SPECIAL ME" Self Portrait Art Contest



The New Jersey Child Advocate's "SPECIAL ME Self Portrait Contest" is open to all New Jersey children and youth between the ages of 4 and 17. Contestants are asked to draw or paint a self portrait that shows they are special and unique. Portraits will be judged based on artistry and creativity, and each winning portrait will be exhibited in the official online gallery of the New Jersey Office of the Child Advocate Web site (childadvocate.nj.gov).

WHAT: Submit a painted or drawn self portrait on 11" x 14", or larger, paper. On the back of the portrait, write the artist's name, age, full address, parent's or guardian's name, and daytime phone number. If applicable, write the name of the contestant's school and grade at time of submission. All portraits become the property of the Office of the Child Advocate.

WHEN: Submissions must be received by January 16, 2006. All submissions become the property of the Office of the Child Advocate, and contestants and their parents or guardians agree to have the portrait work displayed in the official online gallery of the New Jersey Office of the Child Advocate Web site.

WHERE: Please send all submissions to:

Office of the Child Advocate
135 W. Hanover St. - 3rd Fl.
PO Box 092
Trenton, NJ 08625

Child Advocate Ribbons will be awarded in six categories:

Best Portrait, Artist Age 4 to 6;

Best Portrait, Artist Age 7 to 9;

Best Portrait, Artist Age 10 to 12;

Best Portrait, Artist Age 13 to 15;

Best Portrait, Artist Age 16 to 17; and

The Child Advocate Gold Ribbon Prize for Overall Best Portrait

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Every Single Child is Worth the World.